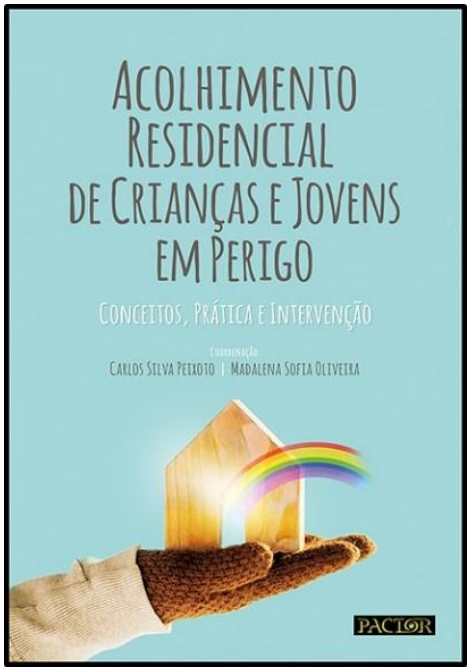
ASSESSMENT OF NEEDS

PATRICK TOMLINSON (CHAPTER 10)

Residential Reception of Children and Youth in Danger - Concepts, Practice, and Intervention (Acolhimento Residencial de Criancas e Jovens em Perigo (2021) Editors - Carlos Silva Peixoto and Madalena Sofia Oliveira)



ASSESSMENT OF NEEDS

Introduction

Assessment can be considered as a way of evaluating the present situation, how history has impacted upon this, and what may be needed for the future. A useful assessment of a child will give us a clear picture of how she or he is today. However, there are many ways an assessment can be carried out. For example, the particular focus of the assessment and who does it. There are probably hundreds of assessments that can be used for different or similar purposes. For children and young people who are either in or possibly entering the care system, we need a holistic assessment. It will look at all aspects of development and functioning. It should highlight current strengths and capabilities as well as vulnerabilities and risks. It must include physical, psychological, emotional, spiritual, and cultural domains.

The assessment will not only give us a clear picture of the child and her functioning it will also help us understand her history. With this understanding, we will hopefully arrive at a good sense of what the child now needs to help her develop. An effective assessment identifies needs and is not just a diagnosis or a label. Unfortunately, many children entering care have

collected a multitude of labels from assessments and not much clarity on what they need. These assessments can provide a narrow view of the child. Perhaps they were only carried out by a doctor, or a psychologist, and other important views on the child were left out. Those working with the child are then left trying to piece the fragments together to make sense of her. If we want to understand the whole child and all her needs, we must use an inclusive assessment. One that includes as many experiences of the child as possible. This might include the child herself, family members, other carers, teachers, social workers, doctors, and other professionals.

PART 1 – Placement Referral Needs Assessment

> You can have assessment without treatment, but you certainly can't have treatment without assessment. (Ward, 2004, p.9)

This important point by Adrian Ward means that assessment must be integral to providing therapeutic services, which help children heal and develop. The first assessment, before placement, is to identify the child's difficulties, strengths, and needs. It is also to begin understanding the experiences that have shaped who he is. Centre for Excellence (2006. p.46) explains important aspects of the referral assessment,

> Careful and comprehensive intake assessment will need to be provided so as to identify the young people that can and cannot be assisted; to identify the areas of need that must be addressed; to develop meaningful intervention and case plans; to match the young person with suitable residential and educational options; and to minimise risk for the young person, his/her peers and staff.

At this stage, the assessment may need to be done by a multi-disciplinary team. For instance, a psychiatrist, psychologist, educational psychologist, family social worker, etc. They may work together or carry out their assessments independently. The aim is to identify whether there are any specific diagnoses, such as a learning disability or mental illness, as well as the child's overall level of functioning and development. Where a child is either in care or being taken into care, there may be numerous, difficulties identified. These could range from behavioural difficulties to psychiatric disorders. It is also important to identify areas of positive functioning. The quality of the assessment must be of a high standard. Zelechoski et al., (2013) state,

> It is well established that the high level of victimization and traumatic exposure for youth in residential treatment programs is often underreported and, thus, underestimated (Singer 2007). Consequently, careful assessment and detailed clinical information gathering is crucial to understanding the unique symptom presentation of these youth and implementing appropriate and effective interventions.

In any assessment, there is a risk of seeing only the behaviour and lose sight of the whole child. Even when the behaviour is identified there may be little understanding of the underlying reason. For example, ADHD may be diagnosed, but trauma may be the most significant issue. Medication may be prescribed but the underlying trauma may remain misunderstood and untreated. Tomlinson and Philpot (2008) point out,

> A label disguises the child; it doesn't tell us who she really is, it prevents us from seeing that whole self.

The pioneering Educator, George Lyward, "… passionately opposed to any labelling of a girl or a boy. He regarded labels as masks, and as ways to bind people in" (Harvey, 2006, p.122). Lyward (1958, p.8) wrote of labels, "Labels put you in your place, but the place they put you in is on the periphery."

To make matters worse there is also the possibility of misdiagnosis. Kezelman and Stavropoulos (2012, p.xi) point out, that this has been common throughout history where trauma is concerned. Often just one fragment of the problem is captured by a diagnosis, such as ADHD or Conduct Disorder, and the overarching problem of trauma in the person's life is overlooked (ibid, xxx). This is partly because Complex Trauma has never been recognized as a distinct diagnosis. As Herman (1992, p. 123) points out, this then leads to a risk that the individual will be re-traumatized within the medical and care system. Another unfortunate result of this problem can be the inappropriate use of medication. Read et al (2008, p.249) highlight this from the perspective of the service user,

> We leave the last words to a group of service users who, during the planning of the Auckland training program, were asked what they thought about asking all patients about child abuse. 'There were so many doctors and registrars and nurses and social workers in your life asking you about the same thing, mental, mental, mental, but not asking you why. I think there was an assumption that I had a mental illness and you know because I wasn't saying anything about the abuse I'd suffered no one knew. I just wish they would have said, "What happened to you? What happened?" But they didn't'.

As well as assessing what is observed of the child in the present, a thorough history of the child needs to be collected and understood. As Perry and Hambrick (2008, p.40) simply put it,

> In order to understand an individual one needs to know his or her history.

Without this, we may be able to describe all of the child's difficulties and 'disorders' but be no closer to understanding them. A label may be attached to the child that does nothing to help him. It may even make matters worse by causing misunderstanding and sometimes, unnecessary stigma. As Van der Kolk (2014, p.185) says,

> If their history is not known, they are likely to be labeled as crazy or punished as criminals rather than helped to integrate the past", and (ibid, p.165) …a mislabeled patient is bound to be a mistreated patient.

Gathering the information together to create a coherent history can be a challenging and painstaking task. As well as collecting information from case records it may also be necessary to interview significant people in the child's life. Using a helpful metaphor, Phillips (1988, p.51) says that,

> The details of the child's life may be like beads that are all over the place waiting to be strung together, and they can of course be strung together in a variety of ways.

A lack of knowledge of the child's history may contribute to the superficial approach mentioned above. This is probably one of the most serious matters for children taken into the care system. They are often misunderstood and then placed inappropriately. The care home or foster family thinks they are getting one kind of child but finds another whom they do not have the resources to work with. The situation breaks down and the child is moved. Further adversity is suffered by the child and unfortunately, this can become a pattern. Whilst assessment may lead to a diagnosis with a label, the most important thing is that the child's needs are identified. A label or diagnosis is only a means to an end. And that end is understanding what the child's needs are.

Children's Needs

Every child is unique and will have specific needs. These may be familial, medical, psychological, attachment, learning and spiritual, cultural among others. All areas need careful consideration. Therapeutic work should not take place in a vacuum. Residential Care has not always paid enough attention to the importance of family involvement, and other important areas such as the child's cultural and ethnic identity. This has been shown in numerous research studies, summarized in the international statement of Whittaker, et al. (2016). These matters can be so important that the location of the new placement can be one of the main influences on the placement decision. However good a therapeutic service, moving a child too far away from family and community may be very damaging. On other occasions, the child's safety may be the main factor in deciding where he should live. He may need to be moved away from dangerous risks.

Again, it is so important to understand the child's history. Children in the 'care system' have usually had some deprivation of their primary needs during the formative years. This can range from inconsistent or disrupted care to privation. Deprivation means the loss of something, or not having enough, whereas privation means having suffered the complete absence of most basic needs. The extent and nature of the deprivation or privation, how long it was for, how early it began, and how frequent has a major influence on the child's development. Emotional, sexual, and physical abuse are also very relevant in this picture. We need to see the whole child

and understanding his history is vital to that. Van der Kolk et al. (2007, p.420) explain what should be included. When they talk of a patient the same applies to the children we work with,

> Prior to the start of treatment, a thorough history needs to be taken. This should include the nature of the traumatic stressor; the patient's role in the traumatic experience; the patient's thoughts and feelings about actions taken and not taken; the effect of the trauma on the patient's life and perception of self and others; exposure to prior traumatic experiences; habitual coping styles; level of cognitive functioning; particular personal strengths and capacities; prior psychiatric history; medical, social, family and occupational history; and cultural and religious explanatory beliefs.

As many children in 'out-of-home care', will have suffered trauma and adversity in early childhood, it is especially important to understand their experiences of parents and other caregivers. Perry and Szalavitz (2006, p.83) make an important point about this,

> And so, since we tend to care for our children the way we were cared for ourselves during our own childhoods, a good "brain" history of a child begins with a history of the caregiver's childhood and early experiences

While the child's difficulties are likely to stand out in his case history, we should also be careful to identify anything positive. The aim of assessing the child's needs is to inform the decision about the type of intervention needed. Does the child need a psychiatric service? Residential care or foster care? A disability service? If we know broadly what type of service, then what are the specific needs? How do age, gender, religion, ethnicity, and culture influence what is needed? If residential care is needed, is it a small or large group? A specialist therapeutic service or not? Answering these questions and others is a complex process. Sometimes it may help for a child to spend a few days with a service where a thorough observational assessment can take place. Many behaviours are significantly influenced by the environment. It can be difficult to tease out which of the child's apparent difficulties have become a pattern in him, and which are more symptomatic of the environment he is in. Sometimes, what appears to be serious difficulties change quite quickly once a child is moved to a new environment.

The Service Provider and their Task

Good quality assessment before placement will not be much use unless service providers are clear about their task. This means having a very clear understanding of the type of child their service is for. Whittaker et al. (2016, p.100) highlight that the terms, residential care and therapeutic residential care do not capture the immense variability between different services. The terms are too vague to know exactly, which category of needs a home may be suitable for. They argue that greater precision and specificity in description are needed. This is essential when it comes to the decision of where to place a child. Some of this is simple, such as for boys or girls, of a certain age. After that, it is more challenging! Is it for short or long-term placements or both? What is short and long-term? Is a secure or semi-secure environment

needed? Is the aim to provide stability before a child returns to his family? Is it to provide treatment? If so, for what? Is it for complex trauma or sexually harmful behaviour?

We can see that many of these questions are interrelated. The service provider must be clear about how their service is defined. They must also be clear that the population for whom they offer a service is appropriate. For example, in some cases, it is not a good idea to mix boys or girls, or very young children with teenagers. Then there is the question of the children's needs and difficulties. In one place I worked we only admitted children whose development had been seriously disrupted by trauma. They all had histories of trauma, often abuse and neglect, beginning early in life. The commonality of the children's needs enabled a very clear and strong therapeutic approach to be developed. However, after many years of work, it was realized that there were certain stages of development in the children, that were not good to mix. So, instead of continuing with one type of home for all children, we created two distinct types of home with different tasks. One we called a primary house and the other a secondary house. Children were placed in each house according to an assessment of their needs. Most children came into the primary house and then progressed to the secondary house as they developed. However, in some cases, a higher-functioning child could be admitted straight into the secondary house.

Even when a service or home is clear about its task and who it is for, other variables can influence the decision-making process. The home may have taken in a new child, or two, and may not be ready for another. So, even though the home is suitable for a child, it may not work to take him now. One more new child may unbalance a group that is already feeling unstable and stretched. Or the group may have many children that have very low functioning, and a child with a little better functioning is needed to balance the group. One experience I have had of this is assessing each child in terms of where they are along a development pathway. We had a simple scoring system from 1-5, with 1 being the lowest level of functioning and 5 moving towards age-appropriate. It wasn't especially scientific, but whenever the average score for a group fell below 2, serious difficulties often escalated. A bit like having 5 babies instead of 5 children of more spaced-out ages. Another factor that is real and foolish to ignore is anything else going on in the service that may influence what is possible. For example, are there any major changes taking place that may make it a challenging time to take in a new child? How experienced is the staff team? A more experienced team is usually capable of dealing with a more challenging group of children.

All these issues of assessment related to identifying needs and placement are important. The service receiving the child should check to ensure that all relevant information and assessments are provided. I have known for a service to insist upon an up-to-date psychiatric report. This may not always be necessary, but where there is the possibility of serious mental health issues, such as psychosis, there are major risks when assessment and full information are not provided. The service provider must have some control over its boundary and the decision about whether to accept a referred child.

Unfortunately, there are situations where this doesn't happen and there is a lack of consultation. Sometimes this is for external reasons and sometimes for internal. For example, there may be an arrangement where a local government places a child with little process. In some cases, a child arrives at a home with less than 24 hours' notice. This may be suitable for emergency services but can often be very problematic outside of that. Mainly this is because there is no preparation for anyone involved, especially the child, but also the staff and other children. On other occasions, the internal management of an organization may put pressure on homes to admit children. This may be done thoughtfully for appropriate reasons, or sometimes it is a reaction to other pressures, such as financial. How the decisions are made is vital to the culture of the organization and the outcomes for children. There are no easy answers, but there must be a process that feels helpful and ultimately in the best interests of the child (Anglin, 2002). Once a referral is accepted there must also be a well-organized plan for the child's transition into the home. Anglin (2004, p.188) states how the assessment and intake processes need to be fully integrated,

> In order to ensure that accurate, timely, relevant and complete information is available for case decision-making, while at the same time minimizing duplication in information collection, a coordinated and seamless intake and assessment process is required.

This section, of the chapter, may have asked more questions than it has given answers. The questions are, however, so important that much of what happens during the placement is dependent on getting as many answers as right as possible at the beginning.

PART TWO - Placement in a Therapeutic Residential Home

I am now going to assume that a child is placed in a therapeutic residential home, though much of this section may also be more widely relevant. Once the child is placed in an appropriate home, there will be a period of settling in and getting to know him. It can be a quiet period in the work with the child who may be in a highly fearful state of frozen watchfulness. This may last a few weeks or months. During the first three months, it is likely to be clear whether the initial assessment is affirmed. There are occasions when something unexpected is experienced with the child, which may bring into question the accuracy of the referral assessment. Even in well-organized services with thorough processes, I have seen children placed who turned out to be inappropriate. For example, who needed to be in a psychiatric hospital rather than a residential care home. It can be very difficult to identify everything correctly. It may also be that the new environment brings something into focus more clearly.

It is good practice to adopt an approach to therapeutic work that maintains a high level of observation and reflection. It could be said that ordinary attunement is a form of assessment. A 'good enough' parent is attuned to their child, in such a way that small changes are noticed. These changes may signify a new development, a new need, and a different approach from the parent. Often, without even realizing it a parent is assessing their child's development and needs.

In therapeutic work with traumatized children, whose needs can be very complex and difficult to understand, this kind of attunement is essential. Even more so, it needs to be made explicit and shared with others. Where understanding a child can be so challenging, noticing anything that may help reach the child and 'unlock a door', can be hugely valuable. So, compared with ordinary parents, those looking after and working therapeutically with children in care need very well-developed skills and support systems.

Ongoing Assessment

The sole purpose of any service for children is to improve outcomes in the short and long term. Therefore, the assessment process enables a child's progress to be monitored and measured over time. This is what has been referred to as evidence-based practice, or perhaps more appropriately as practice-based evidence. A good ongoing assessment system is a vital part of the therapeutic culture. As Tomlinson and Philpot (2008, p.14) state,

> Assessment is a continuing process that allows us to evaluate how successful the initial assessment was, how effective is the treatment offered and what modifications, if any, are then required.

The aim of an ongoing assessment process, as said, is to identify progress, but most importantly to identify needs. The two are also inter-related. For instance, it may be that progress is not being made because the child's needs have not been identified and/or are not being met. There are various aspects to an ongoing assessment process. One is an assessment that casts light on certain key issues, such as that by a psychiatrist or educational psychologist. However, the most important assessment is that of those who live and work with a child. This is a process of 24-hour-a-day living. Those working with a child may gain some important knowledge and a helpful perspective from a professional, such as a psychiatrist. However, the insights gained by a team's observation, interaction, and reflection are the most compelling. Therefore, all staff must be trained and supported in making assessments. Ward (2004, p.9) argues,

> What matters most…is that the whole team is engaged in the process of assessment and in the process of treatment.

Dockar-Drysdale, who named a pioneering assessment she created in 1970, 'Need Assessment' states,

> …all needs assessments must, in my view, be made by a group, *never* by an individual collecting information or depending on interview procedure. (1993, p.94).

The service will need to have its own assessment process. Any assessment should be based on measuring where a child is - in moving towards the most important outcomes. The outcomes need to be most important to the child's positive development and long-term potential. Therefore, being clear about what the desired long-term outcomes are is essential. Once we are clear about what the desired outcomes are, the next question is, how do we know when a child

is moving towards these outcomes? Thompson (2008, p.7) argues, "If we are to have an outcome-based approach, then this places considerable emphasis on high-quality assessment." The assessment questions should be designed to illuminate the child's most important needs. Asking the right questions is the key issue. For example, if being able to form relationships is an important outcome, what kind of questions will tell us whether this is being achieved? Part of this process requires those working with the child, to reflect on their interactions. For example, am I providing the right approach? How do I feel about the child and how is this affecting my approach? Assessment is only useful when it provides information that helps us make an individual plan to meet children's needs. Generally, useful assessment questions should help identify needs in key areas such as,

- Attachment and forming healthy relationships with adults and peers
- Communication individually and in groups
- Family relationships
- Cultural needs and support networks
- Identity and personal narrative
- Strengths and areas of interest
- Emotional and physical well-being and development
- Sexual development and sexuality
- Ability to regulate emotion
- Learning, education and skills development
- Safety and specific risks

An example of specific assessment questions is included in the appendix.

Assessment as Part of a Therapeutic Culture

Hillan's (2006) study into key features in the delivery of high-quality services, affirmed the importance of comprehensive in-depth assessment before and throughout the placement, with individual plans based on an assessment of therapeutic needs. Coman and Devaney (2011, p.50) argue that,

> It is only through having a holistic and sophisticated approach to the assessment of a child's needs that meaningful measurement of the outcomes for a particular child can be achieved.

A good assessment and individual plan process are also one of the best ways of continuously affirming therapeutic culture. A regular assessment that asks the most relevant questions ensures that everyone is reminded of and thinking about the most important issues. For example, a simple question such as – 'Does the child show empathy', is a continuous reminder of the importance of empathy. New staff are introduced to the assessment questions and concepts behind them. And the established staff are reminded of them. Therefore, a good assessment process also serves as a form of training. It also helps establish a shared language. This is very helpful, especially where there are multi-disciplinary teams. Care workers,

therapists, psychologists, etc. learn to talk and think with each other using a common language. The assessment process helps everyone practice using the shared language regularly until it becomes ingrained into the organization's culture. Dockar-Drysdale (1990, p.154) explains how the process of carrying out an assessment together can also help improve understanding and communication, and ultimately more effective work with children,

> As the unit teams became accustomed to using needs assessment, there was a considerable opening up of communication, especially because, for the first time, people began to take some share of the responsibility for boys' acting out. I felt it was safe to say – and say again – that all acting out results from a breakdown in communication.

When there is not a regular shared process such as assessment, the different professionals are more likely to compete to establish a hierarchy. In this situation the language of one discipline becomes dominant. The underlying message can be that one discipline, such as Psychology is the most competent, rather than all disciplines being valued equally for offering a unique perspective. This problem is not helped when the care work profession often tends to be undervalued. Therapeutic care work is a challenging task and should be valued alongside other tasks such as therapy. These are two distinct parts of what a child may need, with neither being more important. However, where children are placed in residential care because of serious difficulties in their history, as Perry and Szalavitz (2006, p.79) said,

> We learned that some of the most therapeutic experiences do not take place in "therapy," but in naturally occurring healthy relationships, whether between a professional like myself and a child, between an aunt and a scared little girl, or between a calm Texas Ranger and an excitable boy.

Assessment that values the input of all those involved with the child can play a vital role in 'joining-up' everyone. Cant (2002) refers to this as part of 'joined-up psychotherapy'. The insights of all involved inform each other, rather than just those of one 'expert'. Any useful assessment must be reliable, provide useful information, and be possible to administer in the context where it is used. There is no point in having assessments that are too demanding to administer, or easy to administer but do not add much value in understanding the child and his needs. Prior and Glaser (2006, p.88) have defined the right balance as one that is clinically useful. An important question regarding the administration of assessment is how frequent should it be? 6 months allows enough space to see how interventions are working. It is also frequent enough to identify a child's progress and whether a different approach is needed. Mini-reviews can take place every 3 months, between the full assessments.

As said, everyone who is involved with the child should be included. This may include residential care workers, therapists, teachers, and family. One of the values in this is the different perspectives that are contributed. Children who have suffered trauma, tend to present themselves differently to different people and in different contexts. For instance, the assessment may highlight whether a child responds differently to male or female carers, or

whether a child presents differently at home and school. When different people in the same or different contexts of a child's day-to-day life see a different child, it does not mean that one person's assessment is better than another's. It means that different people are seeing different parts of the child. For example, one person might see strengths and another vulnerability. The different perspectives create a whole picture of the child. This holistic approach helps us see the whole child and not just one part. As traumatized children are often fragmented, joining-up the different parts is vital to holding the whole child in mind. Tomlinson and Philpot (2008), explain the value of the holistic approach,

> This is where we see the child as her problem or as the sum of her problems rather than as a child first and foremost. It doesn't let us see Lucy, only the self-harmer; it doesn't picture Tom but only the sexually aggressive 10-year-old. It is also a kind of labelling which focuses on the child's deficits rather than her strengths, that sees her as passive, rather than someone who, with help, can participate in her own recovery.

Griffin et al. (2009) have argued that a focus on strengths can have a helpful effect on moderating behaviour and helps to build resilience. Involving the child in the assessment may also be very helpful and illuminating. How does he perceive his own progress and development? How much of a difference is there between the child's view of himself compared with those working with him?

The Assessment Paperwork and Meeting

In practical terms, there needs to be a clearly designed assessment form and evaluation process. Typically, the number of questions that can be evaluated and fully considered is between 20-25 or so. The questions will all be related to the key outcome areas in the child's development. A simple scoring system may be used. Such as 1-4 to identify whether a child has a poor or a good level of functioning in each area. Each score should be supported by some relevant evidence. To understand a child's level of functioning and how his development has been disrupted it is first necessary to have a theory of 'true' child development. Therefore, training in this is essential.

Some of the assessment paperwork can be prepared in advance of an assessment meeting. The task of the meeting will be for everyone who is working with the child to consider the assessment together – to clarify, ask questions, and arrive at a shared understanding of the child, his progress, and his needs. An assessment meeting of up to 1 ½ hours can provide enough time to do this well. The questions may first be answered by a lead person such as a keyworker. There will be preliminary discussions and scoring of the assessment before the meeting.

It is useful to have a photograph of the child projected at the meeting, a reminder of him (literally) so that he is held in mind throughout the discussion. To involve the child, he should be asked to choose which picture he would like displayed. The picture which he chooses will give an insight into how he sees himself over time. For example, a child may first choose a picture

where he is in the background but later choose one where he is much more prominent. This may suggest a greater sense of self-esteem and assertiveness (Tomlinson and Philpot, 2008, pp.104-105).

To help ensure the history of the child is kept in mind it is important to remind ourselves of the child's history before each assessment. A synopsis of the history can be written and agreed to be an appropriate representation. This can always be updated whenever any new information comes to light. Bloom (2005, p.75) in her work on the Sanctuary Model highlights the importance of this,

> Since it is evident that the traumatic history frequently is "lost" over time, the core team will also develop a plan to ensure that the trauma history is reviewed and discussed at all relevant team meetings.

The assessment meeting may then begin by reflecting upon the child's assessment scores and discussing differences of opinion. It is not unusual that there may be quite different views of the child. The meeting needs to give enough space to reflect upon the points of view and arrive at a rounded view of the child. Sometimes, a team or individual may give a score that does not seem supported by evidence. This may be because the child is provoking feelings in the workers, which distort reality. A negative score may hide real progress that is being made and vice-versa. I can think of assessments where a team had a negative view due to strong anxieties about the child that prevented them from recognizing positive progress. And other occasions where a team reported positively on a child when they were defended against seeing the real difficulties involved. It can be difficult to keep an objective view when there are so many powerful dynamics involved. Dockar-Drysdale (1970, p.90) explains,

> All the *feelings* of the worried people engulfed in the crisis, are going to be in the assessment and also all the feelings of the workers who are making the assessment.

Therefore, it can be helpful that the assessment process is overseen by an experienced practitioner who is not directly involved in the work with the child. Such a person may chair an assessment meeting. This person's task may be to help the team explore their assessment and to ask questions where something seems unclear or out of place. This external perspective can help ensure a level of objectivity in the process. As Van der Kolk et al. (2007, p.418) have shown, it is possible for those involved directly with a client, to reach a view on the progress that is not supported by other measures.

It can also be helpful to have a way of cross-checking the assessment, such as a child seeing a psychologist or psychiatrist every 12 months or so. Assuming an assessment seems valid the next question to consider is, what does this tell us about the child's needs? The assessment should identify the key areas of need. At least 3-4 key areas of need should be identified. These needs will be the focus of work for the next 6 months. An example might be the need for clear and consistent boundaries.

Individual Therapeutic Plan

Once an area of need is identified, the question is, how can this be met within the context of the child's 24-hours-a-day life? The starting point for any therapeutic plan must be to ensure that it has a clear focus on the child's safety. Within the plan, there will be all kinds of implications for the child's daily routine, such as his waking and bedtime routines, how food and mealtimes are provided, and how relationships with adults and peers are managed. As Perry (2014, p.22) explains from a neurobiological perspective,

> … optimal caregiving, teaching, and therapeutics require awareness of the child's developmental capacity as well as his or her current internal "state" of arousal (Perry 2008). This means that developmental age, and not chronological age, in any given domain is the best indicator for where to target educational and therapeutic experiences; due to the complex developmental experiences of maltreated children, they often have wide variation in their developmental capabilities across domains of functioning.

Following the assessment, a complete 24-hours-a-day therapeutic plan should be created or updated. The child should be involved as much as appropriate in creating the plan. There may be things that he can identify as being helpful or unhelpful. As Stein (2005, p.428) points out, "Young people feeling able to plan and be in control is a key contributor to their resilience building." Research by Griffin et al. (2009) found that an optimal plan, as well as addressing clinical problems also builds strengths, which reduce the impact of traumatic experiences. Once discussed with the child the plan can be shared with others such as family and social worker among others. They may also have ideas to contribute.

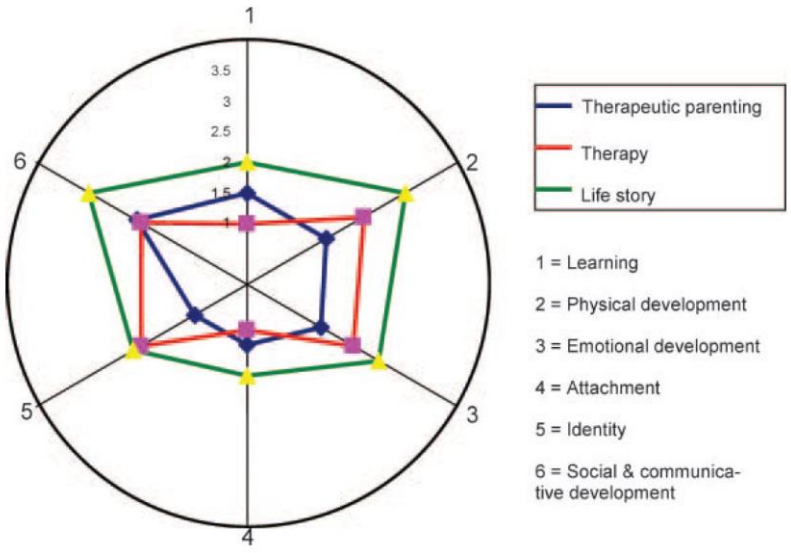
When an individual plan is agreed it is then essential that everyone involved works consistently toward the plan. Whenever a plan or part of it does not seem to be working or needed any longer it can be reviewed and amended. The 6-monthly assessment will fully review the child's progress and consider any changes that need to be made to the plan. Therefore, the ongoing process has 4 stages - assess, plan, implement, review, and so into the next cycle (Sutton, 2001, p.169). One of the positive things about ongoing assessment is that progress is continuously reviewed, and plans adapted. This can help prevent drift and ensure that a child's present needs remain in focus.

Visualizing Progress

Often work with traumatized children is slow and progress is incremental. Assessment can help identify small changes. This can be invaluable to those working with the child as well as to the child. Small steps can be recognized and celebrated. This raises the question, what is the best way of showing progress? I have found that a visual representation can be a powerful way of doing it. In one organization we carried out a consultation on how to do this with all the staff involved. The options considered were various forms of a graph and a spider diagram, sometimes known as a wheel or radar diagram. Overwhelmingly, people chose the spider diagram and we found that it worked very well. I think this is partly because it symbolically

captures the sense of the healthy child and the small or damaged child within. This can be seen as the small 'ego core' of the child as it grows over time, towards a 'well-rounded child' (Tomlinson, 2008, p.369).

We used a circle, with 6 spokes each representing one of 6 outcome areas. The average scores from the assessment questions in each area could then be plotted on each spoke. The circumference represents normative functioning for the child's age. The points on each spoke can be joined up to form a spider diagram. The closer the picture created is to the circumference the closer the child is to normative development. The gap between where the child is now and the circumference represents the level of support required by him. At the beginning of the placement, it can be expected that the gap will be significant. Van der Kolk (2007, p.2004) stated, "traumatized people tend to become fixated at the emotional and cognitive level at which they were traumatized". Barbara-Dockar Drysdale (1990, p.29) and more recently Bruce Perry (2014) have also said that recovery must begin from the point of failure, i.e., from the child's developmental stage rather than chronological age. However, as Perry (2014, p.22) points out this can be complex as the child may have different levels of functioning in different areas, such as, "the self-regulation capacity of a 3-year-old, the social skills of an infant, and the cognitive capabilities of a 5-year-old." An assessment helps to set realistic expectations of the child, which are based on the child's development rather than chronological age. This does not mean that we limit our expectations of the child's potential, but recognise that he has major obstacles, which will take time to overcome (Morgan, 2013, p.9). Here is an example of a child's first assessment represented on a spider diagram,



In this diagram, there are 3 assessments of the same child. The blue is by the therapeutic parenting (care) team, the red by the child's therapist, and the green by his life story worker. As we can see, everyone sees a child whose development is significantly disrupted and who has huge needs. However, there are differences in the 3 pictures. This is a child that Winnicott (1962) may have called 'Unintegrated', or Solomon and George (1999), a child with

'Disorganised Attachment'. He will be different things to different people at different times, compliant one minute and chaotic the next. We can see that the blue shape is furthest away from the circumference. The care workers who live with him 24 hours a day are seeing more real difficulties. The therapist is seeing some of the challenges, but the 1 hour a week therapy is in the early stages. The child has just started seeing a life story worker and sees this as a fun experience, which he can manage reasonably well.

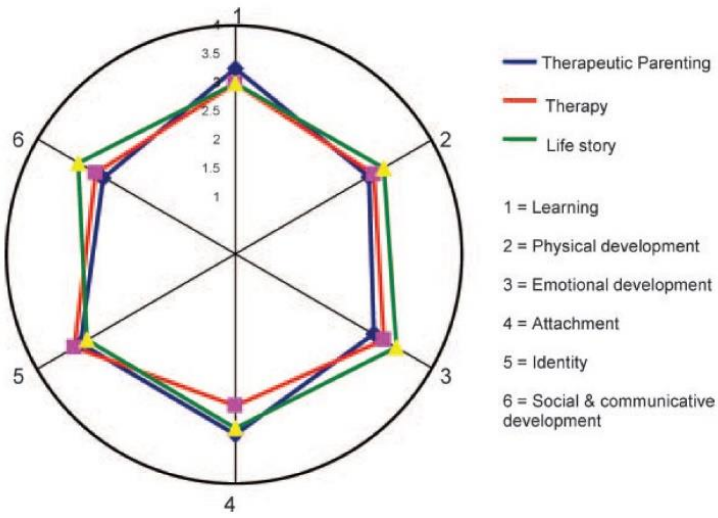
Where a child is progressing steadily, at each 6 monthly assessment he can be seen moving closer to the circumference of normative functioning. If a diagram is produced (on clear acetate, for example) for each 6-monthly assessment, they can be laid on top of each other to see progress. Referring to the work of the psychologist, Lev Vygotsky, Tomlinson (2008, p.369) explains,

> This gap is similar to Vygotsky's (1978) concept of the 'Zone of Proximal Development', or, how the child is able to function on her own compared to how she could function with the input of others (Mooney, 2000). The support necessary to enable the child to move from where she is now to where she could be, Vygotsky termed 'scaffolding'.

Macdonald and Millen (2012, p.10) argue that this approach can help enhance a child's developmental competencies. When assessing children's progress, it is important to keep in mind that sometimes a child may appear to go backward. While this may be concerning, it can also be part of the progress. Sometimes things must get worse before they get better, and there may be a step back for every two steps forward. As Keggereis (1995) stated in her aptly named paper, "Getting Better Makes It Worse". As a child progresses it is likely that as well as moving towards the circumference of normative development, he is also perceived more consistently by different people in different contexts. This can be considered as an indicator of recovery. There is an integrated and coherent sense of self emerging.

Assessment Towards the End of Placement

Ideally, the ongoing assessment process will show the child moving toward the desired outcomes that were identified at the beginning of his placement. The assessment diagram at this stage may look more like this,



The progress towards the circumference is clear to see. As are the more consistent views of the therapeutic parenting (care) team, therapist, and life story worker. As the child is maturing, he presents himself more consistently in different relationships. He is becoming integrated and his attachments are more secure. However, recovery is not a cure but a lifelong journey. As Dockar-Drysdale (1993, p.50) said,

> I really want to jettison the concept of 'cure' at once, and replace this by 'evolvement'.

The best situation is for the child to move on when he is ready. Hopefully, this means that he is now able to autonomously apply what he has learned about himself and the relational world. In a therapeutic care programme, the young person internalizes things, such as what it is like to be loved and thought about, what a parent should be like, what a home is like, what a healthy relationship looks like, and so on (Barton et al., 2011, p.234).

Skills development is also an important yardstick in assessing the young person's readiness for transition. This can be considered under individual, relational, and community wellness (Prilleltensky and Nelson, 2000). For instance, individual wellness considers physical health and developmental milestones. Relational wellness considers attachment, healthy relationships, and networks of friends. Community wellness considers access to safe accommodation, community networks, employment, and education. The young person must develop mastery across these three major domains to ensure that the transition is successful (Barton et al., ibid).

However, in some cases, progress may not have been as positive as hoped for, or there may be another reason the placement has to end early. Whatever the situation, the assessment task at the end is to identify where the child has got to in his development. What are his strengths and areas of vulnerability? Most importantly, the child's needs for a positive transition must be identified. This can be vital to his future. Just as the late stages of adolescence and early adulthood are so significant to the longer-term wellbeing of young people, it can be even more so for those with histories of major childhood adversity. A clear transition plan based on an

assessment of need is vitally important. If this is done well, everything gained from the placement can likely be maintained and built upon into the future.

Conclusion

It can be argued that effective assessment is at the heart of good quality care and positive outcomes. Only effective assessment can help us understand a child and her needs. An assessment leads to a plan or an intervention. We cannot have effective plans without effective assessments. This is true whether we are talking about formal assessment processes or the kind of informal processes of weighing up any situation we are in and trying to work out what to do.

It could be argued that children who end up needing to be assessed have not had a good enough experience of the informal and natural processes that take place in families. Often intuitively, parents work out what their children need at any given moment. They have a good enough understanding of children's needs in general and specifically of their own. They understand the needs of their children and respond appropriately. Children who enter care bring with them, histories of being misunderstood and of not having their needs met. This chapter has shown how vital good assessment processes are for these children. This is true for the assessment at the pre-care stage, throughout the care process, and leaving care. The last stage of the process must appraise the progress that has been made, areas where support is needed, and how this will be provided in the future.

Appendix – Example of Assessment Questions and Scoring

This might be one section of an Assessment format. For example, emotional Development might be 1 of 6 areas assessed. Under each assessment area, there will be several questions, in this case, 6.

Emotional development

Here, we are concerned with the child's capacity to cope with, express, and understand emotions, both in themselves and others. The areas for consideration, along with examples of the questions which allow us to define them, are as follows.

1. Emotional regulation: Emotional expression (How does he express herself? Do expressions of emotion equate to the emotional experience?) and internal experience of emotions (Does he experience distress? Is emotional distress extreme in relation to its cause? Is he overwhelmed by his emotions?).
2. Disruption of others: Does he disrupt an activity between others? How does he manage jealousy and attention given to peers?
3. Range of emotions: Is he able to experience a range of feelings, such as sadness, happiness, and anger? Does he recognize these feelings in others?
4. Capacity for empathy: Does he feel a sense of concern towards others and make appropriate reparation? Is he able to take the perspective of another person, to step into their shoes?
5. Guilt: Does he show a capacity for appreciation of the hurt or disappointment he may have

caused? Does he seem to feel appropriate concern for his actions?

6. Choice selection: How does he consider options and make choices? Does he seem to become overwhelmed by uncertainty?

The child is scored under each question with a simple scoring system. For example,
1 = Severe concerns; poor functioning in this area
2 = Substantial concerns; some signs of progress but a range of aspects to address
3 = Moderate concerns; one or two aspects to address
4 = Positive functioning in this area, possibly some minor concerns

As progress between one score and another can be very incremental, ½ scores can be given, i.e. 1.5, etc. The chosen score is the one closest to the child's current level of functioning. As an explanation of the score, brief anecdotal evidence should also be provided.

Scoring guidelines to explain what each score means for an assessment question should be defined and provided. For example, for **Question 2. Disruption of others:** Does he disrupt an activity between others? How does he manage jealousy and attention given to peers?

The scoring guidelines might be,

1 = Cannot cope with more than one relationship. Needs constant adult support. Very jealous and possessive: will become aggressive if not given instant gratification.
2 = Will seek adult attention and is disruptive if cannot get his way.
3 = Can function without adult attention; enjoys contact with other children but becomes argumentative if he feels threatened. Does not resort to violence.
4 = Can cope with multiple relationships and generally not feel threatened by others.

The guidelines need to consider the age of the child. For example, a healthily developed child of any age over 5 years might be expected to score 3-4.

Tomlinson and Philpot (2008, pp.122-124)

References

Anglin, J. (2002) *Pain, Normality, and the Struggle for Congruence: Reinterpreting Residential Care for Children and Youth*, New York: The Haworth Press Inc.

Anglin, J. P. (2004) Creating "Well-Functioning" Residential Care and Defining Its Place in a System of Care, in *Child and Youth Care Forum, 33 (3), June 2004*, Canada: Human Services Press, Inc.

Barton, S., Gonzalez, R. and Tomlinson, P. (2011) *Therapeutic Residential Care for Children and Young People: An Attachment and Trauma-informed Model for Practice,* London and Philadelphia: Jessica Kingsley Publishers

Bloom, S. (2005) The Sanctuary Model of Organizational Change for Children's Residential Treatment, *Therapeutic Communities: The International Journal for Therapeutic and Supportive Organizations, 26(1):61-78*

Cant, D. (2002) Joined-up Psychotherapy: The Place of Individual Psychotherapy in Residential Therapeutic Provision for Children, in, *Journal of Child Psychotherapy 28*, 267–281

Centre for Excellence in Child and Family Welfare (2006) *Residential Care – Not the Last Resort: An Intervention to Meet the Needs of Children and Young People,* Melbourne, Australia: Centre for Excellence in Child and Family Welfare

Coman, W. and Devaney, J. (2011) Reflecting on Outcomes for Looked-after Children: An Ecological Perspective, in, *Child Care in Practice, vol. 17, No. 1, January 2011*, 37-53, Routledge

Dockar-Drysdale, B. (1970) Need Assessment – 1, Finding a Basis, and Need Assessment – 11, Making an Assessment, Dockar-Drysdale, B. (1993), *Therapy and Consultation in Child Care*. London: Free Association Books

Dockar-Drysdale, B. (1990) *The Provision of Primary Experience*. London: Free Association Books

Dockar-Drysdale, B. (1993) *Therapy and Consultation in Child Care*, London: Free Association Books

Griffin, G., Martinovich, Z., Gawron, T. and Lyons, J. S. (2009) Strengths Moderate the Impact of Trauma on Risk Behaviors in Child Welfare, in *Residential Treatment for Children and Youth*, 26, p. 105–118

Harvey, J. (2006) *Valuing and Educating Young People: Stern Love the Lyward Way*. London and Philadelphia: Jessica Kingsley Publishers

Herman, J.L. (1992) *Trauma and Recovery*, New York: Basic Books

Hillan. L., (2006) *Churchill Fellow Report. Reclaiming Residential Care – A Positive Choice for Children and Young People in Care*

Keggereis, S. (1995) Getting Better Makes It Worse: Obstacles to Improvement in Children with Emotional and Behavioural Difficulties, in, Bower, M. and Trowell, J., *The Emotional Needs of Young Children and Their Families: Using Psychoanalytic Ideas in the Community*, London and New York: Routledge

Kezelman, C. and Stavropoulos, P. (2012) *The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* Australia: Adults Surviving Child Abuse (ASCA) https://www.recoveryonpurpose.com/upload/ASCA_Practice%20Guidelines%20for%20the%20Treatment%20of%20Complex%20Trauma.pdf

Lyward, G. (1958) *Unlabelled Living*. Conference talk for the Residential Care of Disturbed Children, National Association for Mental Health, 5–11 March

Macdonald, G. and Millen, S. (2012) *Therapeutic Approaches to Social Work in Residential Child Care Settings: Literature Review*, SCIE (Social Care Institute of Excellence): Institute of Child Care Research, Queens University Belfast https://www.scie.org.uk/publications/reports/report58/files/literaturereview.pdf?res=true

Mooney, C.G., (2000) *Theories of Childhood: An Introduction to Dewey, Montessori, Erikson, Piaget and Vygotsky*, Redleaf Press: St. Paul, Minnesota

Morgan, M. (2013) *Blame my Brain: The Amazing Teenage Brain Revealed*, London, Boston, Sydney and Auckland: Walker Books

Perry, B.D. and Szalavitz, M. (2006) *The Boy who was Raised as a Dog: And Other Stories from a Child Psychiatrist's Notebook* New York: Basic Books

Perry, B.D. (2008) Child Maltreatment: The Role of Abuse and Neglect in Developmental Psychopathology, in Beauchaine, T.P. and Hinshaw, S.P. (Eds.), *Textbook of Child and Adolescent Psychopathology*, p.93-128, New York: Riley

Perry, B.D. (2014) The Neurosequential Model of Therapeutics: Application of a Developmentally Sensitive and Neurobiology-Informed Approach to Clinical Problem Solving in Maltreated Children, in Brandt, K., Perry, B.D., Seligman, S. and Tronick, E. *Infant and Early Childhood Mental Health: Core Concepts and Clinical Practice*, Washington D.C. and London: American Psychiatric Publishing

Perry, B.P. and Hambrick, E.P. (2008) The Neurosequential Model of Therapeutics, in, *Reclaiming Children and Youth,* Vol. 17, No. 3, p. 38-43, https://www.cpe.rutgers.edu/NJDCF2014/The_Neurosequential_Model_of_Therapeutics_as_Evidence_based_Practice.pdf

Phillips, A. (1988) *Winnicott,* London: Frontier Press

Prilleltensky, I. and Nelson, G. (2000) Promoting Child and Family Wellness: Priorities for Psychological and Social Interventions, in *Journal of Community and Applied Social Psychology 10*, 2, 85–105

Prior, V. and Glaser, D. (2006) *Understanding Attachment and Attachment Disorders*. London and Philadelphia: Jessica Kingsley Publishers

Read, J., Fink, P.J., Rudegeair, T., Felitti, V., and Whitfield, C. (2008) Child Maltreatment and Psychosis: A Return to a Genuinely Integrated Bio-Psycho-Social Model, in *Clinical Schizophrenia and Related Psychoses*

Solomon, J. and George, C.C. (Eds.) (1999) *Attachment Disorganisation*, New York: Guildhall Press

Stein, M. (2005) *Resilience and Young People Leaving Care: Overcoming the Odds,* York: Joseph Rowntree Foundation

Sutton, C. (2001) Reviewing and Evaluating Therapeutic Progress, in, Palmer, S. and McMahon, G. (eds.) *Client Assessment*, London: Sage

Thompson, N. (2008) Focusing on Outcomes: Developing Systematic Practice, in *Practice 20 (1) March 2008*

Tomlinson, P. (2008) Assessing the Needs of Traumatized Children to Improve Outcomes, in *Journal of Social Work Practice Vol. 22, No. 3, pp. 359–374*

Tomlinson, P. and Philpot, T. (2008) *A Child's Journey to Recovery: Assessment and Planning with Traumatized Children,* London and Philadelphia: Jessica Kingsley Publishers

Van der Kolk, B.A. (2007) The Complexity of Adaptation to Trauma: Self-Regulation, Stimulus Discrimination, and Characterological Development, in van der Kolk, B. A., McFarlane, A. C. and Weisaeth, L. (eds.) *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society,* New York: Guilford Press

Van der Kolk, B.A., McFarlane, A.C. and Van der Hart, O. (2007) A General Approach to Posttraumatic Stress Disorder, in *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society* New York: The Guildford Press

Van der Kolk, B. (2014) *The Body Keeps the Score: Brain, Mind and Body in the Healing of Trauma*, Viking: New York

Vygotsky, L.S. (1978) *Mind and society: The development of higher psychological processes*. Cambridge, MA: Harvard University Press

Ward, A. (2004) *Assessing and Meeting Children's Emotional Needs*, Lecture notes presented at the Therapeutic Childcare Study Day, University of Reading

James K. Whittaker (USA), Lisa Holmes (GBR), Jorge F. del Valle (ESP), Frank Ainsworth (AUS), Tore Andreassen (NOR), James Anglin (CAN), Christopher Bellonci (USA), David Berridge (GBR), Amaia Bravo (SP), Cinzia Canali (ITA), Mark Courtney (USA), Laurah Currey (USA), Daniel Daly (USA), Robbie Gilligan (IRL), Hans Grietens (NLD), Annemiek Harder (NLD), Martha Holden (USA), Sigrid James (USA), Andrew Kendrick (GBR), Erik Knorth (NLD), Mette Lausten (DNK), John Lyons (USA), Eduardo Martin (ESP), Samantha McDermid (GBR), Patricia McNamara (AUS), Laura Palareti (ITA), Susan Ramsey (USA), Kari Sisson (USA), Richard Small (USA), June Thoburn (GBR), Ronald Thompson (USA) & Anat Zeira (ISR) (2016) Therapeutic Residential Care for Children and Youth: A Consensus Statement of the International Work Group on Therapeutic Residential Care*, in, *Residential Treatment for Children & Youth, 33:2, pp.89-106,* https://www.tandfonline.com/doi/full/10.1080/0886571X.2016.1215755

Winnicott, D.W. (1962) Ego Integration in Child Development, in, Winnicott, D.W. (1990) *The Maturational Process and the Facilitating Environment,* London and New York: Karnac Books

Zelechoski, A.D., Sharma, R., Beserra, K., Miguel, J.L., DeMarco, M. and Spinazzola, J. (2013) *Traumatized Youth in Residential Treatment Settings: Prevalence, Clinical Presentation, Treatment, and Policy Implications,* New York: Springer Science and Business Media http://www.traumacenter.org/products/pdf_files/Youth%20Trauma_Residential%20Treatment_Prevalence_Policy_Zelechoski_Spinazzola.pdf

PATRICK TOMLINSON 2020

DEVELOPING PEOPLE AND ORGANIZATIONS

ASSESSMENT OF NEEDS

Patrick Tomlinson Brief Bio: The primary goal of Patrick's work is the development of people and organizations. Throughout his career, he has identified development to be the driving force related to positive outcomes - for everyone, service users, professionals, and organizations. His experience spans from 1985 in the field of trauma and attachment-informed services. He began as a residential care worker and has since been a team leader, senior manager, Director, CEO, consultant, and mentor. He is the author/co-author/editor of numerous papers and books. He is a qualified clinician, strategic leader, and manager. Working in many countries, he has helped develop therapeutic models that have gained national and international recognition. In 2008 he created Patrick Tomlinson Associates to provide services focused on development for people and organizations. The following services are provided,

- Therapeutic Model Development
- Developmental Mentoring, Consultancy, & Clinical Supervision
- Character Assessment & Selection Tool (CAST): for Personal & Professional Development, & Staff Selection

Web Site – www.patricktomlinson.com **Contact** – ptomassociates@gmail.com